St. Paul Lutheran Preschool

Student Physical Examination

Today's Date ________________(Must be after June 1st of current year)

Name of Child ___________________________ Age _______ Birth Date _____________

Past health history (list any surgeries, accidents, illnesses or special problems) __________________

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Status of present health ____

Blood Lead Level ________________________

Allergies _______________________________ Medications ______________________________

Acute or chronic conditions ____

Does the examination reveal any abnormality or limitations? ___________________________________

Are the child's immunizations up to date? Yes No
If no, please describe ____

__________________________________is healthy and free of any communicable diseases and may participate fully in the Preschool program.

** Please complete the back side of this form if child has any special medical needs**

____
Printed name/stamp of health provider

____
Signature of health provider

____
Phone number

Care Plan for a Child With Special Needs in Child Care

Today's Date ______________

Full Name of Child	Birth Date	Child's Present Weight
Parent's/Guardian's Name (Please * first person to contact.)	Cell/Home/Work Phone #	Signature for Consent*
Emergency Contact Person (Name/Relationship)	Cell/Home/Work Phone #	*Consent for health care provider to communicate with my child's child care provider to discuss information relating to this care plan.
Primary Health Care Provider	Emergency Phone #	Authorization for Release of Information Form completed? ☐N/A ☐Yes ☐No
Specialty Provider	Emergency Phone #	Emergency Information Form for Children With Special Needs completed? ☐N/A ☐Yes ☐No
Specialty Provider	Emergency Phone #	Specialty Care Plan(s) completed? ☐N/A ☐Yes ☐No

Allergies ☐No ☐Yes If yes, please specify.		
Medical Conditions		
Needed Accommodations: (Please describe accommodation and why it is necessary.) Diet/Feeding Classroom Activities Nap/Sleep	Toileting Outdoor or Field Trips Transportation	
Recommended Treatment		
Medications to be Given at Child Care ☐No ☐Yes Specify medications on Medication Administration Forms.		If yes, Medication Administration Forms completed? ☐Yes ☐No
Medications Given at Home ☐No ☐Yes		If yes, please list in additional information section or attach info.
Special Equipment/Medical Supplies ☐No ☐Yes		If yes, please list in additional information section or attach info.
Special Staff Training Needs ☐No ☐Yes		If yes, please list in additional information section or attach info.
Special Emergency Procedures ☐No ☐Yes		If yes, please list in additional information section or attach info.
Other specialists working with this child ☐No ☐Yes		
Parent Signature Acknowledging Review of Above Information		
Additional Information/Comments on Child, Family, or Medical Issues		Additional Information Attached ☐No ☐Yes
Health Care Provider's Signature		**Health Care Provider's Name Printed**